

BUDGET OF THE UNITED STATES GOVERNMENT



Fiscal Year 1995

4. REFORMING THE NATION'S HEALTH CARE SYSTEM TO PROVIDE HEALTH SECURITY FOR ALL AMERICANS

Every American must have the security of comprehensive health benefits that can never be taken away. That is what the Health Security Act is all about.

President Bill Clinton
transmitting the Health Security Act
to the Congress, September 1993

Why We Need to Reform the Health Care System Now

The Moral Imperative

On September 22, 1993, President Clinton submitted the Health Security Act to the Congress. The central premise of the Act is that *all* Americans need health security—the knowledge that quality medical care will always be available and affordable.

Every year, many people lose their insurance for some period of time, usually because they work for small businesses that can no longer afford it. We all face the same predicament: the 85 percent of Americans who have health insurance do not have health security, because even the insured are often just one serious illness away from exhausting their health benefits and finding themselves unable to renew their coverage.

Another predicament we face is that although the U.S. has the best medical care in the world, that care is not always available to the 15 percent of Americans—38.5 million people¹—who do not have coverage because they are sick or poor or because they work for businesses that cannot afford it. All Americans need medical care at some time, but uninsured Americans frequently are unable to pay for the care they receive. These costs are then shifted to those with private

insurance. Health reform should make health care affordable for all.

The Economic Imperative

The cost of health care threatens America's economic future. Rising health costs drain resources away from other productive uses, threaten the competitiveness of American firms, add to the Federal deficit, and reduce national savings. The U.S. spends more of its economic output (as measured by Gross Domestic Product, or GDP) on health care than any other industrialized country. Today, 14 percent of U.S. GDP is devoted to health care, and by the end of the decade that number is projected to rise to slightly more than 18 percent.² By comparison, no other industrialized country spends more than 10 percent of its output on health care—and most of those countries insure all of their citizens.³ We spend the most, insure the fewest, and rank 20th in the world in preventing infant mortality, 19th in fatal heart disease, and 16th in life expectancy.⁴

The Federal Government spends about 19 percent of its budget on health care. If current trends continue, that percentage will rise to 25 percent by 1998. Health care will consume almost 50 percent of Federal spending growth between 1993 and 1998.

² Congressional Budget Office, *Projections of National Health Expenditures, 1993 Update*, October 1993, p. 3.

³ Organization for Economic Cooperation and Development, *Annual Report, 1993*.

⁴ Organization for Economic Cooperation and Development, *OECD Health Data, 1960–1991*.

¹ Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey*, Special Report and Issue Brief Number 145, January 1994, p. 4.

The story is the same at the State and local level. In 1960, State and local governments spent 8 percent of their budgets on health; in 1992, that figure rose to about 15 percent.⁵

Health care spending is crowding out other important investments. Here's one example: In 1962, the Federal Government spent roughly the same amount on education and training as on health care—about \$1.2 billion. In 1992, the Federal Government spent twice as much, or \$90 billion, on health care, excluding Medicare, as on education. The situation is the same at the State and local level. While health costs are rising as a proportion of State and local government expenditures, transportation spending has fallen from 18 percent in 1960 to 10 percent in 1992.⁶

The rise in health care costs has meant lower wage growth for American workers. Businesses generally respond to higher health care costs by foregoing wage increases for employees. Similarly, the taxes required to finance government health care spending are borne by workers in the form of lower wages. If employer contributions to health insurance had remained constant at their

1975 share of compensation through 1992, and if employers had passed the difference on to workers in the form of wages, real wages per worker would have been more than \$1,000 higher in 1992.⁷

The lack of health security hinders economic flexibility and hurts overall productivity. American workers with employer-based health insurance voluntarily change jobs 25 percent less frequently than do workers whose employers do not provide coverage—in part because widespread pre-existing condition clauses prevent workers from obtaining coverage from their new employers.⁸ Others are discouraged from forming small businesses or becoming self-employed because of the difficulty of obtaining insurance. Many others stay on welfare because they fear they will lose Medicaid coverage for their children—and not be able to replace it—if they take a job.⁹

The growing portion of Federal and State budgets devoted to health care costs is reason alone for health care reform. When combined with health care's drag on the overall economy and personal economic status, health reform becomes an economic imperative.

Q. What is the relationship between universal coverage and cost containment?

Universal coverage is an essential tool for controlling health costs. Currently, the uninsured pay only 20 percent on average of the hospital costs they incur, while the privately insured pay 130 percent of their hospital costs, as hospitals pass on their unpaid bills in the form of higher prices to people with private insurance.¹⁰ According to one recent estimate, the insured will pay for about \$25 billion of uncompensated care in 1994.¹¹ Universal coverage will eliminate most uncompensated care, reducing costs to firms that now provide coverage and making resources available for higher wages, more jobs, investment in plant and equipment, or lower prices. Universal coverage will also mean that people who use emergency rooms as health care of last resort will be able to afford more appropriate care earlier, which will also help to restrain cost growth.

⁵ Congressional Budget Office, unpublished data from HCFA National Health Accounts, November 1993. Also see *Survey of Current Business*, Vol. 73, No. 9, September 1993, Bureau of Economic Analysis, Department of Commerce. Also see *National Income and Product Accounts*, Vol. 2, 1959-1988, September 1992, Bureau of Economic Analysis, Department of Commerce.

⁶ *Survey of Current Business*, Vol. 73, No. 9, September 1993, Bureau of Economic Analysis, Department of Commerce. Also see *National Income and Product Accounts*, Vol. 2, 1959-1988, September 1992, Bureau of Economic Analysis, Department of Commerce.

⁷ OMB staff calculation based on data from the National Income and Product Accounts.

⁸ Madrian, Brigitte, *Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?*, NBER Working Paper No. 4476, September 1993.

⁹ One estimate is that as many as 25 percent of the 4 million welfare recipients would leave welfare for employment under health care reform. See Douglas Holt-Eakin, *Health Insurance Provision and Labor Market Efficiency in the United States and Germany*, NBER Working Paper No. 4388, 1993.

¹⁰ Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress*, June 1993.

¹¹ OMB staff calculation based on 1991 data in S. Christensen, "Single Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," CBO Staff Paper, April 1993.

Why We Must Act Now

There is a national consensus on the scope and severity of the health care problem. Across the country, Americans agree that the health care crisis cannot be ignored.

The costs of doing nothing are enormous. Without reform, health costs will consume an additional \$56 billion of our national output in the year 2000—money that could more than double Federal spending on transportation or education and training. Put another way, these savings could also boost productivity and wage growth by increasing the resources available to lift capital invested per worker by roughly half.¹² If current trends continue, real wages will be further eroded by almost \$600 per worker by the end of the decade. If we do not curb increasing health costs, we will not be able to continue bringing down the deficit or make the investments in jobs and infrastructure that we need to keep the U.S. economy healthy.

Americans recognize that without reform, health insurers will continue to drop coverage for people when they get sick and price others out of the market entirely. One in four Americans will lose their health insurance at some point in the next two years without health reform. Fewer jobs will be created and rapidly rising health care costs will continue to hinder productivity. Government and businesses alike will continue to spend ever-increasing amounts on health care, lowering the national saving rate and crowding out new investment capital. The longer we wait, the harder it will be to restrain increasing costs and the less we will have to leave to future generations.

The President's Six Principles of Health Care Reform

The Health Security Act is the most detailed, comprehensive, and responsible health care reform plan ever offered. The President's plan commits to six principles for reform; fixing what is broken, while preserving what works in our current system.

1. Security

This principle speaks to the human misery, to the costs, to the anxiety we hear about every day . . . when people talk about their problems with the present system.

President Bill Clinton
September 1993

Security means that those who do not now have health coverage will receive it; and those who do have coverage will never have it taken away. The Act will provide every American with a Health Security card and a comprehensive package of benefits guaranteed over an entire lifetime. The guaranteed benefits will be comparable to packages offered by most Fortune 500 companies today.

One important way the Act achieves security is through insurance reforms. Health plans will not be able to refuse or discontinue coverage to people with pre-existing conditions, nor will they be able to raise premiums for people who become sick. In addition, people will not see a break in their coverage when they change jobs or if they become unemployed.

2. Simplicity

A hospital ought to be a house of healing, not a monument to paperwork and bureaucracy.

President Bill Clinton
September 1993

To refer to the current health care delivery and insurance mechanisms as a "system" is a misnomer. "System" implies a coordinated effort—practically the opposite of how we provide and insure health care now. There are over 1,500 insurers in the U.S. with thousands of different forms, eligibility requirements, and reimbursement conditions. Myriad insurance forms, for example, are time-consuming for providers and consumers and require a byzantine overhead apparatus to process.

The Health Security Act will implement ONE standard claims form for physician office visits and will standardize other forms. Once we develop consensus standards for automation, administrative information will be transmitted electronically while protecting privacy. The goal of simplification is to move towards a paperless system as quickly as

¹² Schultze, Charles L. *Memoes to the President*, The Brookings Institution, Washington, D.C., 1992, p. 246.

possible and to minimize the administrative burden on consumers and providers.

In addition, the President's plan will simplify the rules and regulations that have contributed to past inefficiencies. The Act seeks to streamline quality assurance regulations by setting minimum Federal standards that are performance-based; coordinating annual quality-related surveys; revising Medicare peer review organization activities; and changing Federal regulation of clinical laboratories by eliminating requirements for labs performing simple tests.

The principle of simplicity goes beyond reducing administrative costs—simplicity also means making health insurance choices more clear. Individuals and firms will no longer have to sort out the different plans, options, and limitations offered by various insurers. Instead, they will be able to look to their health alliance to provide the complete price and quality information they need to make sound decisions from a wider range of choices than most have access to today. The standard, comprehensive benefit package will give them a solid basis for comparison.

3. Savings

People may disagree over the best way to fix this system ... But we cannot disagree that we can find tens of billions of dollars in savings from what is clearly the most costly and the most bureaucratic system in the entire world.

President Bill Clinton
September 1993

The Health Security Act introduces a simple market force into the health care system: competition. Organized into large purchasing pools, consumers and small businesses will have the same bargaining power that large corporations have now to negotiate with health plans for lower rates on better health coverage.

The Health Security Act also saves health care dollars by giving consumers a financial stake in their choice of health plan (and information on which to base that choice). Experience has shown that employees choose

lower cost plans when they are given adequate information and the financial incentive to do so.¹³ Health plans will compete against one another on price and quality—not on their ability to select low risk enrollees. The Act also encourages providers to join together in groups that will provide care as cost-effectively as possible and use lower premiums to compete for consumers.

4. Choice

The choice will be left to the American citizen, the worker—not the boss, and certainly not some government bureaucrat.

President Bill Clinton
September 1993

One of the most dearly held features of health care in America is the right to choose one's own doctor and health plan. But under the current system, the employer often makes the initial choice of health plan. Rising costs have forced many employers to offer only one health plan, as 40 percent of those who offer coverage do now. Their employees have no real choice of plans and, frequently, a limited choice of providers.

The Health Security Act will give every American a choice among at least three plans and usually more. Individuals can stay with their current doctors, join a network of doctors and hospitals, or join a health maintenance organization. An annual open season will allow people to choose or change plans. Even those who do not sign up with a health plan prior to seeking care will be able to enroll at the point of service—when they visit their doctor. Further, the Act will ensure that doctors are free to apply to practice in the plan of their choice, and the Act allows doctors to participate in more than one plan.

¹³Feldman, R. and B. Dowd, "The Effectiveness of Managed Competition in Reducing the Costs of Health Insurance," in Robert B. Helms, *Health Policy Reform: Competition and Controls*, The AEI Press, 1993.

5. Quality

If we reformed everything else in health care, but failed to preserve and enhance the high quality of our medical care, we will have taken a step backward, not forward.

President Bill Clinton
September 1993

The United States enjoys medical care that is envied the world over, but in today's system doctors and hospitals get paid more to treat people after they become sick than to keep them healthy in the first place. The health system needs incentives that emphasize preventive care. The Health Security Act's comprehensive benefit package includes a wide range of preventive health services, which many health plans do not cover today. Many of these preventive services have no out-of-pocket costs, to encourage consumers to take advantage of them.

We also have to strengthen our system of monitoring and assuring quality. For too long, health care data have been collected with an eye toward counting health care dollars, not evaluating cost-effectiveness or success in treatment.

The Health Security Act will assure quality by requiring health plan performance reports so consumers will have the information they need to choose the highest quality doctors and hospitals. Minimum quality and performance measures will help consumers compare quality across plans. Plans and providers demonstrating the highest levels of quality at a reasonable cost will receive the most business, and other providers will have a financial incentive to keep improving quality to attract more customers.

6. Responsibility

Responsibility in our health care system isn't just about them, it's about you, it's about me, it's about each of us. Too many of us have not taken responsibility for our own health care and for our own relations to the health care system.

President Bill Clinton
September 1993

Americans must take responsibility for being part of the solution to a health care crisis that affects us all. Responsibility means that insurance companies should no longer be allowed to cast people aside when they become

sick. It also means that all employers and employees will be asked to pay their fair share for health insurance. No longer will some "free riders" get health care while responsible employers pay their bills. Businesses that do not provide insurance will not be able to continue to shift costs onto those that do.

Responsibility must apply as well to laboratories that submit fraudulent bills, to lawyers who abuse malpractice claims, and to doctors who order unnecessary procedures.

Responsibility also means that people must change the behavior that contributes to rising health costs. Smoking, violence, excessive drinking, illicit drug use, and teen pregnancy all drive up health care costs. One important way the Act asks risk takers to pay for the extra costs they impose on the health care system is through increased excise taxes on tobacco products. The Congressional Office of Technology Assessment (OTA) estimates that smoking-related illness leads to \$21 billion in direct medical costs and another \$47 billion in economic costs associated with disability and death every year.¹⁴

What the Health Security Act Will Do

Health insurance that cannot be taken away. The first building block of the Health Security Act is health security for every American. The Act guarantees that every individual will have continuous coverage for a comprehensive package of health benefits, no matter whether the individual works for a large or small company, is self-employed or unemployed, or works full-time or part-time. This guarantee cannot be taken away under any circumstance. Changing jobs, leaving the work force, starting a business, going back to school—none of these changes will cause a break in coverage for any American.

The Act assures the security of universal continuous coverage by requiring all employers and all workers with sufficient income to contribute. All employers will pay 80 percent of the average premium for the standard, comprehensive benefit package (described

¹⁴ Office of Technology Assessment testimony before the Senate Special Committee on Aging, May 6, 1993.

Table 4-1. **SMALL FIRM PREMIUM CAPS**
(As a percent of payroll)

Average wage	Firm Size			
	<25 workers	25-49 workers	50-74 workers	75+ workers
<\$12,000	3.5	4.4	5.3	7.9
\$12,000-\$15,00	4.4	5.3	6.2	7.9
\$15,000-\$18,00	5.3	6.2	7.1	7.9
\$18,000-\$21,00	6.2	7.1	7.9	7.9
\$21,000-\$24,00	7.1	7.9	7.9	7.9
>\$24,000	7.9	7.9	7.9	7.9

below) calculated on a per worker basis for full-time employees and a pro rata share for part-time employees. Individuals and families are responsible for the remaining 20 percent of their alliance's premium for the comprehensive benefit package. If they choose a plan that costs less than the average, they will pocket the savings. If they choose a higher cost plan, they will pay a little more.

Individuals and families with adjusted gross incomes (AGI) below \$40,000 will be eligible for discounts that will ensure they pay no more than 3.9 percent of AGI for their share of the cost of health coverage. Individuals and families with income below 150 percent of poverty will receive extra discounts.

Employers in the regional alliance system will pay no more than 7.9 percent of payroll for insurance premiums; and small, low-wage firms will receive additional discounts to make their insurance affordable, consistent with the schedule in Table 4-1.

One responsibility of those proposing change in the health care sector is to minimize disruption wherever possible. Currently, 80 percent of all workers are offered insurance by their employers,¹⁵ and 84 percent of the uninsured are in families that have at least one employed member.¹⁶ Building

on the employer-based system is the least disruptive way of achieving universal coverage.

Comprehensive benefits for all Americans. Although millions of workers have no choice of health plans, those workers fortunate enough to be able to choose are now confronted with plans that differ from one another according to benefits, cost-sharing, price, and the size and quality of provider networks—so many variables that it may be difficult to compare plans without actuarial and medical advice. The second building block of the Health Security Act is a standardized, comprehensive package of insurance benefits that all health plans will offer, allowing consumers to compare plans according to price and quality.

Consumers will choose among three different cost-sharing arrangements. Under the low cost-sharing option, enrollees will pay a \$10 copayment for outpatient services, \$25 for outpatient psychotherapy and some emergency room services, and \$20 for some dental visits. Under the high cost-sharing option, enrollees will pay an annual deductible (\$200 for individuals, \$400 for families) and, after the deductible, coinsurance of 20 percent. Under the combination cost-sharing option, enrollees will pay the low cost-sharing charges for services received from providers within a network, and high cost-sharing charges for services from providers outside of the network. All three cost-sharing options contain

¹⁵ Urban Institute's TRIM2 model, 1993.

¹⁶ Employee Benefit Research Institute, p. 9.

an annual out-of-pocket limit of \$1,500 for individuals and \$3,000 for families.

The comprehensive benefits in the Health Security Act include:

*Visits to doctors and other health professionals
Hospital services
Prescription drugs
Preventive services
Emergency medical and surgical services
Mental illness and substance abuse services
Family planning services and services for pregnant women
Home health care
Extended care services
Ambulance services
Outpatient lab, radiology, and diagnostic services
Outpatient rehabilitative services
Durable medical equipment
Vision care
Dental care
Hospice care*

Benefits for services such as mental health and dental are fully phased in after January 1, 2001.

Health alliances. The third building block of the Health Security Act is the health alliance, a purchasing pool with a board of directors equally divided between consumers and employers. The purpose of the alliances is to improve competition by increasing the purchasing power of individual consumers and small businesses.

The alliance will include workers in firms with fewer than 5,000 full-time employees (as well as those in larger firms that choose to join the regional alliances), the self-employed, non-workers, and current Medicaid recipients. Each State will have at least one alliance; and in a State with multiple alliances, only one alliance will operate in a given geographical area. Each alliance must offer consumers at least one fee-for-service plan.

Alliances will streamline health bureaucracy and reduce overall administrative costs by reducing the administrative burden on individual plans, business, and consumers. Like large companies do now, alliances will solicit

bids from potential health plans, review the bids to make sure the plans can offer all covered services, determine consumers' eligibility for premium and cost-sharing discounts, and collect premiums from employers and consumers.

Health alliances will collect detailed information from plans on the quality of care provided by the plans, including outcomes data. The alliances will then provide this information in an annual report card so consumers can more directly compare quality measures across plans. Examples of the type of information the alliances will collect include: access to care (e.g., time to next available appointment); appropriate use of medical care (e.g., immunization and mammography rates); and outcomes (e.g., survival rates for cardiac arrest).

Corporate alliances. The Act enables companies with more than 5,000 full-time employees to provide coverage to their employees through corporate alliances. Corporate alliances will function much like regional alliances, accepting bids from plans and collecting premiums from employees. They are also required to offer their employees a choice of at least three plans, one of which must be fee-for-service. Firms that choose to establish their own corporate alliances will be assessed 1 percent of payroll to finance their fair share of support for community-wide expenses such as academic health centers and graduate medical education. Large firms may also choose to join the regional alliance system.

Health plans and insurance reforms. The fourth building block of the Health Security Act is the individual health plan and the new environment in which it will operate. Once a health plan's bid has been accepted by the alliance, the plan will conduct open enrollment during which the plan must accept all enrollees, regardless of health status or history, employment, age, or income. Plans must offer each enrollee the comprehensive benefit package in its entirety, and may not limit coverage for any services in the comprehensive package because of an enrollee's health status or pre-existing condition.¹⁷

¹⁷ During transition to the new system, health plans may exclude coverage for treatment of pre-existing conditions for not more than

Q. Will people be able to choose their own doctors?

Yes. The Health Security Act requires each regional and corporate alliance to offer its members at least one fee-for-service plan, where individuals can choose any doctor they want. Moreover, alliances must accept bids from all plans that offer the comprehensive benefit package at premiums within 20 percent of the per capita premium target and meet minimum quality, solvency, and grievance procedure standards. The typical enrollee will be able to choose from among many fee-for-service plans, staff HMOs, and plans that combine staff providers with a provider network.

Today, insurance companies charge what is called an experience rate—where individuals are charged according to their health experience and those with poor health experiences due to old age or chronic illness are charged more. Under the Health Security Act, all members of a community will pay the same rate—a community rate. Health plans will charge premiums based on the average expected cost of providing coverage to all enrollees for all the benefits in the comprehensive package.

Of course, open enrollment means that some health plans may enroll sicker (and more expensive) individuals than other plans in the same alliance. These plans will incur per-person costs higher than the community-rated premium. To protect plans that enroll sicker individuals, the alliance will assess the health risks for each plan's enrollees and adjust the premium the alliance pays to the plan. Thus, plans that enroll higher-risk individuals will receive higher per-person payments and plans that enroll lower risk individuals will receive lower per-person payments. Therefore, plans will have no incentive to avoid enrolling people with high medical expenses, as many do today. Note that the risk adjustment is made to the amount paid by the alliance to the plan and not to the amount paid by the enrollee. All

6 months for individuals who have not had continuous health coverage for the 6 months preceding enrollment. See section 11005 of the Health Security Act.

enrollees will pay the same amount to the alliance; it is the alliance's responsibility, consistent with nationally-developed methods, to adjust the premiums for risk. The Act gives alliances the flexibility to use traditional reinsurance mechanisms during the transition and authorizes grants for further research in this evolving area.

Because the health plan will receive a fixed amount of money to provide all of the services under the comprehensive package to each enrollee, the plan will have an incentive to provide high quality care as cost-effectively as possible. Plans that cut quality to reduce cost will see their quality ratings decline, and with that, their enrollment. Plans that maintain and improve quality but do not contain costs may not remain solvent. Plans that maintain and improve quality and contain costs will make money and attract enrollees.

Premium Targets. The alliances and accountable health plans in the Health Security Act are designed to contain health costs and maintain quality by strengthening competitive forces within the health care market. But since the Act asks all employers and individuals to pay their fair share into the new health system, it also offers Americans an important guarantee: that their premiums will not spiral out of control, as they have in recent years.

Q. Will people be able to spend their own money to pay for additional health care?

Yes. Individuals may purchase any additional coverage they choose—for example, to assist with copayments or deductibles or services (e.g., cosmetic surgery) beyond the comprehensive benefit package. There are no limits whatsoever on how much people may choose to spend out of their own pockets for additional coverage.

Thus, the fifth building block in the Health Security Act is a system of premium targets that will provide American businesses, consumers, and taxpayers with another aspect of health security: protection against premiums that rise substantially faster than inflation. The Act allows the national per capita premium target to rise by the Consumer Price Index (CPI) plus 1.5 percentage points in 1996, CPI plus 1 point in 1997, CPI plus .5 point in 1998, and by the CPI alone in 1999 and 2000. After 2000, premiums are expected to grow no faster than the growth in real GDP per capita plus inflation. The premium targets exclude payments by individuals for supplemental insurance policies or other out-of-pocket health costs.

In the meantime, the premium targets work this way: The National Health Board will establish a per capita premium target for the comprehensive benefit package in 1996, and then use this national target to establish a per capita target for each alliance, adjusted initially to account for the number of uninsured and underinsured in an alliance area, demographics, health status, and other variables. Every year, the alliances will conduct a bidding process with the health plans in their area. The NHB will then compare the weighted average of the premiums submitted by each alliance to the alliance's target. If the actual premium is below the target, then the State will receive

half of the discount savings.¹⁸ If the weighted-average premium for the alliance is above the target, the alliance will invite plans above the target to submit new bids until the average premium equals the per capita target.

The most effective form of cost containment is to give producers and informed consumers free choice in a competitive marketplace. The targets in the Health Security Act for the growth of insurance premiums are back-stop devices that will most likely never be needed once insurers, providers, and consumers respond to strengthened competition and incentives to become more efficient. The targets also provide the security of knowing that health care inflation will be contained, which must happen if we are to bring personal, business, and government health spending under control.

Moving To Universal Coverage: Transition to Reform

The Health Security Act will provide every American with universal coverage by January 1, 1998, at the latest. States may begin to phase in the new system on January 1, 1996, if they choose. However, because

¹⁸ The lower the premium, the lower the discount the Federal Government will have to pay to make the premium affordable for low-income Americans. If the alliance's weighted-average premium is below its NHB target, the State receives half of the percentage reduction in health spending multiplied by the Federal payment to that State for discounts. The State can use this amount to reduce the State's maintenance of effort payment towards the discount cost for former Medicaid recipients. See Section 6005 of the Health Security Act.

Q. How will low-income families receive coverage under the Health Security Act?

To fulfill the promise of universal coverage for all, the Act provides premium discounts to those who cannot afford coverage. Individuals and families who have less than \$1,000 in income will pay nothing towards their premiums. Those with income between \$1,000 and 150 percent of poverty will pay on a sliding scale from zero to the lesser of 3.9 percent of their income or 20 percent of the weighted average premium.

The Act's method of financing coverage for low-income families breaks the link that now exists between health care coverage and welfare dependency. Individuals and families who are eligible for Federal cash assistance (Aid to Families with Dependent Children and Supplemental Security Income) will be full members of regional alliances and will pay nothing to enroll in any health plan with a premium at or below the weighted-average for the alliance. AFDC and SSI recipients will also receive discounts to help pay for their coinsurance. Severely disabled individuals who now receive coverage for long-term care through Medicaid may stay in the Medicaid program under the Health Security Act, or they may move to the new community-based long-term care program.

Q. How are the elderly treated under the Health Security Act?

While Medicare benefits expand substantially under the Health Security Act, the underlying structure of the Medicare program remains intact. In general, Medicare beneficiaries will continue to receive care through the program as they do now. Upon becoming eligible for Medicare, non-working individuals may choose to join the Medicare program, or they may choose to remain in the regional alliance system. Working Medicare beneficiaries will receive employer sponsored coverage through a regional or corporate alliance (although Medicare will continue to pay their cost-sharing requirements for Medicare-covered services). In any case, they will be able to take advantage of two important new benefits: long-term care for the severely disabled and prescription drugs. For the low-income elderly, Medicaid will continue to cover Medicare's out-of-pocket costs, as under current law, and to provide certain services not covered by Medicare.

38.5 million Americans need coverage now, the Act offers transitional coverage. The Act also includes provisions to help States prepare for reform.

Transitional Risk Pool for the Uninsured.—The Act establishes a transitional risk pool to make health insurance coverage available to people who lose coverage or are unable to obtain coverage because of health status. The transitional pool will be coordinated with States and build on their existing health insurance risk pools. It will offer benefits, conditions of coverage, and cost-sharing comparable to benefits and terms available in existing State pools. The transitional pool will be financed through premiums and contributions by insurers and self-funded plans.

Helping the States Prepare.—Recognizing that many States have already begun reform on their own, the Act builds on these efforts by allowing States to start alliance systems

as early as January 1, 1996. To help States prepare for reform, the Act will also make available planning grants to assist in planning and startup of State systems.

Insurance Reforms.—To protect consumers from breaks in coverage during the transition to reform, the Act establishes interim insurance regulations. These regulations will prevent insurers from terminating coverage of the currently insured, moderate growth in premium increases, prevent plans from imposing preexisting conditions on new employees who were insured in the 90 days prior to employment, and prohibit plans from reducing existing coverage for medical conditions that cost more than \$5,000 to treat.

How the Health Security Act is Financed: Sources and Uses

A key question about any health care reform proposal is how it is financed. About

Q. How will the Act affect the private sector and jobs?

After an initial phase-in period, the Health Security Act will gradually lower aggregate business spending on health insurance, and many employers who currently offer health insurance will see their costs fall. By the end of the decade, aggregate business spending on services covered by the Health Security plan will be \$28 billion less than it is expected to be without reform. In addition, eliminating the cost-shifting caused by uncompensated care will lower costs to businesses that provide coverage. Businesses will be able to do many things with the cost savings: hire more workers; raise wages; invest more in plant, equipment, training, and research and development; lower prices, and increase dividends to shareholders. Each of these will stimulate the economy and help increase employment.

The Health Security Act will also give workers the freedom to move to jobs where they might be more productive without the risk of losing their health insurance. In particular, this will help small businesses, which have had difficulty in the past attracting highly skilled workers. More firms will be able to hire workers with pre-existing conditions, allowing for more efficient matches between employers and employees.

three-quarters of health insurance spending under the Health Security Act comes from the same places it comes from now—businesses and households paying insurance premiums. This section describes the sources and uses of the additional financing called for in the Health Security Act.¹⁹

Sources of Funds

Medicare will realize savings of \$118 billion over 1995–2000 under the Act, which proposes a set of 29 policy changes that will reduce Medicare's average growth rate from its current 11 percent per year to less than 9 percent over 1995–1999 (which is still nearly three times the rate of inflation) by the end of the decade. The policy changes include changes in certain payment rates, to some providers, extensions of certain current law provisions, and some increased beneficiary cost-sharing to reduce excess utilization.

Medicaid will realize savings of \$61 billion over 1995–2000. Medicaid beneficiaries who are not AFDC or SSI cash recipients will obtain coverage through a regional alliance rather than through Medicaid. As many of these people are employed, Medicaid will not finance their premiums; however, these individuals may receive Federal premium discounts. AFDC and SSI cash recipients will also obtain coverage through alliances. Medicaid payments for alliance premiums for cash recipients will grow at the same rate as

private sector premiums, producing significant savings for States and the Federal Government. Additional savings accrue because the Act nearly eliminates uncompensated care, enabling the replacement of Medicaid disproportionate share hospital payments with a much smaller program of targeted payments. Finally, States will have an opportunity to reduce administrative expenses in response to reduced responsibilities in enrollment, oversight, rate-setting, and claims processing.

An increase in the tobacco products excise tax will raise \$67 billion. Billions of dollars of health care costs are related to smoking, and this increase may help pay for some of these costs. This tax increase may also reduce the number of young people who begin smoking in the first place as well as encourage some current smokers to cut back or quit.²⁰

Other Federal programs will realize increased receipts and savings of \$29 billion over 1995–2000. New sources of revenues will be available to the Departments of Veterans Affairs, Defense, and Health and Human Services as their programs are coordinated with the reformed health care system. For example, VA will receive new revenues from now uninsured veterans, and HHS-supported grantees will receive revenues from now uninsured low-income Americans. Premiums paid by Federal employees and retirees

¹⁹These estimates were calculated using the economic assumptions in the 1995 budget. Estimates released in November 1993 were based on the economic assumptions in the 1993 Mideession Review.

²⁰*Smoking and Health in the Americas, A 1992 Report of the Surgeon General, in collaboration with the Pan American Health Organization, U.S. Department of Health and Human Services, p. 129.*

Q. How can we guarantee coverage for all Americans?

The Act entitles every American to comprehensive coverage. It relies on individuals to enroll in a health plan, as well as on the corporate and regional alliances to ensure that eligible individuals enroll and that enrollment procedures are simple and accessible. In turn, every health plan offered through a regional or corporate alliance must accept every eligible person seeking enrollment. The Act prohibits the current practice of insurance companies of attracting or limiting enrollees based upon personal characteristics such as health status, age, anticipated health needs, occupation, or affiliation with any person or entity.

Even persons who do not enroll in a health plan prior to seeking care will be able to get coverage. Alliances will maintain point-of-service enrollment procedures. At the point of service, the provider will notify the alliance of an unenrolled patient's identity and the patient can enroll in a health plan at that time. Every American will be able to walk into a hospital or doctor's office knowing that he or she will have coverage for a comprehensive set of services.

now enrolled in the Federal Employees Health Benefit Program will be lower.

Other Federal revenues will rise by \$93 billion. For example, health reform will reduce the growth in insurance premiums, which will raise taxable income. Money now spent by employers on non-taxable premiums will be available as taxable profits or wages, and the \$28 billion in additional taxes that will result should continue to finance a portion of our health care system.

Contributions from corporate alliances in the form of a 1 percent of payroll assessment will raise \$24 billion. Large corporations will benefit from reduced cost-shifting under health reform and share responsibility for funding a share of the public health system from which all benefit.

Uses of Funds

Premium discounts for businesses and families (\$151 billion over 1995-2000)—To assist those businesses and families who

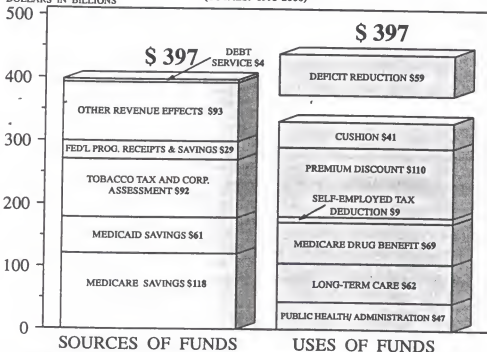
Q. How does the Act address malpractice reform?

The Health Security Act includes several provisions to reform medical malpractice. It encourages consumers and providers to resolve disputes through more informal and less costly mechanisms before litigating. Every health plan will develop at least one alternative dispute resolution process, and every malpractice claim will first go through that process before a suit can be filed. The Act also makes other changes, such as limiting the amount of lawyers' fees to no more than one-third of the amount recovered, requiring lawyers to submit a "certificate of merit" (an affidavit by a qualified medical specialist before filing a suit), and preventing plaintiffs from receiving "windfall" recoveries where insurance is already available to compensate victims for economic damages.

Chart 4-1. FINANCING THE HEALTH SECURITY ACT

DOLLARS IN BILLIONS

(TOTALS: 1995-2000)



NOTE: These estimates were calculated using the economic assumptions in the 1995 budget. Estimates released in November 1993 were based on economic assumptions in the 1993 Midterm Review. Numbers may not add due to rounding.

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Table 4-2. FINANCING THE HEALTH SECURITY ACT
Sources of Funds (billions of dollars)

	1995	1996	1997	1998	1999	2000	1995-2000
Medicare	2.1	9.0	14.3	22.1	31.6	39.2	118.3
Part A Savings	0.0	3.3	7.0	12.0	16.4	20.4	69.1
Part B Savings	1.9	2.4	2.7	5.3	8.7	11.5	32.4
Parts A and B Savings	0.2	1.5	2.2	2.6	4.2	5.0	15.8
HI Tax Extended to all State & Local Government Employees	0.0	1.6	1.6	1.5	1.5	1.5	7.6
Income Related SMI Premium with outlay and premium effects	0.0	0.2	0.9	0.7	0.8	1.0	3.6
Medicaid	0.0	0.8	3.5	9.2	20.1	27.1	60.8
Cash-Eligible Beneficiaries in Alliances	0.0	0.3	1.2	3.7	6.6	9.7	21.5
Reduced Disproportionate Share Hospital Payments	0.0	1.0	3.7	10.4	15.2	17.4	47.7
Less Supplemental Services for Children	0.0	-0.1	-0.4	-1.1	-1.6	-1.6	-4.8
Payment Lag, Administrative Savings, and Other Changes	0.0	-0.4	-1.0	-3.8	-0.1	1.6	-3.6
Other Federal Programs	0.0	0.4	1.2	6.9	9.8	10.9	29.2
Veterans Affairs: Third Party Receipts	0.0	0.6	1.7	4.4	5.8	6.1	18.5
Defense Department Health (a)	0.0	0.1	0.2	0.7	0.8	0.8	2.6
Federal Employees Health Benefits	0.0	-0.2	-0.7	1.8	3.2	4.0	8.2
Tobacco Tax/Corporate Assessment	12.0	15.0	16.2	16.2	16.1	16.1	91.6
Tobacco Tax	12.0	11.3	11.2	11.1	11.0	10.9	67.4
Corporate Assessment	0.0	3.8	5.0	5.1	5.1	5.2	24.2
Other Revenue Effects	0.1	0.8	8.4	20.0	28.8	34.5	92.6
Exclusion of Health Insurance from Cafeteria Plans	0.0	0.0	5.3	8.1	8.7	9.3	31.4
Effects of Mandate, Cost Containment, and Discounts	0.0	0.1	0.9	4.3	9.3	13.7	28.4
Dedicated Revenues for Academic Health Centers	0.0	0.5	1.6	4.4	5.5	5.8	17.7
Assessment on Employers for Retiree Discounts	0.0	0.0	0.0	2.4	4.3	4.7	11.4
Anti-Abuse Rule—Certain S Corp. Shareholders	0.0	0.2	0.5	0.5	0.5	0.5	2.2
Modify Tax Treatment of Certain Health Care Organizations	0.0	0.0	0.1	0.2	0.2	0.2	0.7
Reporting Penalties—Non-corp. Ind. Contractors	0.1	0.1	0.1	0.1	0.1	0.1	0.5
Modify Tax Treatment Retirement Funding Accounts	0.0	0.0	0.0	0.0	0.1	0.1	0.3
Recapture Retiree Discounts High-Income Recipients	0.0	0.0	0.0	0.0	0.1	0.1	0.2
Incentives for Health Providers in Shortage Areas	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Debt Service	0.3	0.6	0.5	0.2	0.6	2.0	4.2
TOTAL	14.5	26.7	44.0	74.7	107.0	129.8	396.8

(a) Under the proposed legislation, the Secretary of Defense is to decide when the military system will be coordinated with national health reform. The table shows the estimated budgetary effects on the Department of Defense if the military system were to be fully coordinated with national health reform by 1998.

Notes:

These estimates were calculated using the economic assumptions in the 1995 budget. Estimates released in November 1993 were based on the economic assumptions in the 1993 Midseason Review.

The numbers in this table for the years 1994-1999 are drawn from the budget database, except that they include the Vulnerable Population Adjustment and a Medicare adjustment based on more recent data than were available at the time the budget database was completed.

are unable to pay their full share, the Health Security Act includes discounts for small and low-wage businesses and low-income families. The Administration's estimates include a 15% "cushion" (another \$41 billion on top of the estimated discounts) to cover behavior changes and economic uncertainties.

Medicare prescription drug benefit (\$69 billion over 1995-2000)—To help elderly Americans afford the cost of prescription drugs, the Health Security Act establishes Medicare

coverage of prescription drugs similar to that which is included in the comprehensive benefit package for Americans under age 65. Medicare will begin to cover outpatient prescription drugs in 1996. The benefit includes a \$250 deductible and 20 percent coinsurance with a \$1,000 annual out-of-pocket limit.

Long-term care benefit (\$62 billion over 1995-2000)—To help ease the burden of caring for elderly and disabled family members, the Health Security Act establishes a new

Table 4-3. FINANCING THE HEALTH SECURITY ACT
Uses of Funds (billions of dollars)

	1995	1996	1997	1998	1999	2000	1995-2000
Veterans, Public Health, New Administration, and Other	3.0	5.2	9.6	8.9	10.0	10.3	47.0
Veterans Health Care Investment Fund	1.0	0.6	1.7	0.0	0.0	0.0	3.3
New Public Health Initiatives	0.4	1.1	1.6	1.3	1.2	1.1	6.7
Net New Spending on Acad. Health Ctrs. and Grad. Med. Educ.	0.3	1.8	3.8	4.9	6.2	6.5	23.5
Advance Practice Nurses (Medicare)	0.0	0.2	0.4	0.5	0.6	0.6	2.2
New Federal Administrative and Start-Up Costs	1.3	0.9	1.2	0.9	0.6	0.6	5.4
Special Supplemental Food Program (WIC)	0.0	0.5	0.6	0.6	0.7	0.7	3.1
Vulnerable Population Adjustment	0.0	0.1	0.3	0.7	0.8	0.8	2.7
Long-Term Care	0.0	5.1	8.8	12.2	16.0	20.1	62.2
Home Based Care for the Disabled	0.0	6.0	10.2	13.9	18.2	22.8	71.1
Medicaid Offset	0.0	-1.5	-2.4	-2.9	-3.5	-4.1	-14.4
Liberalized Medicaid Eligibility and Personal Needs Allowance	0.0	0.4	0.5	0.5	0.5	0.5	2.4
Tax Incentives for Long-Term Care	0.0	0.2	0.5	0.7	0.8	0.9	3.1
Medicare Drug Benefit	0.0	6.9	14.0	15.0	16.0	17.2	69.1
100% Tax Deduction for Self-Employed Health Insurance	0.5	0.6	0.9	1.7	2.5	2.8	8.9
Discounts	0.0	5.8	17.5	41.8	44.3	41.8	151.1
Discounts—Net of Cushion	0.0	4.5	13.6	31.4	31.7	28.8	109.9
Total Discounts	0.0	10.2	31.6	82.7	100.0	103.0	327.4
Employers (net of cushion)	0.0	3.0	9.2	23.7	28.4	28.7	93.1
Non-retired Households (net of cushion)	0.0	4.4	14.0	36.8	45.0	46.7	146.9
Retirees—low income discounts (net of cushion)	0.0	0.7	2.1	5.5	6.7	7.0	21.9
Retirees—added discounts (net of cushion)	0.0	0.4	1.4	3.7	4.5	4.8	14.8
Out-of-Pocket	0.0	0.3	1.0	2.5	2.7	2.8	9.4
Cushion	0.0	1.3	4.0	10.4	12.6	13.0	41.2
Offsets Made Possible by Health Reform	0.0	-4.4	-14.1	-40.9	-55.7	-61.2	-176.3
Medicaid	0.0	-3.4	-12.1	-34.9	-47.7	-53.2	-151.3
States Required Maintenance of Effort ...	0.0	-2.0	-6.4	-18.1	-22.4	-23.4	-72.3
Discontinued Medicaid Coverage	0.0	-1.4	-6.7	-16.8	-25.3	-29.8	-79.0
Basic Benefits	0.0	-1.3	-5.2	-15.2	-22.9	-26.9	-71.5
Wrap-around Benefits	0.0	-0.1	-0.5	-1.5	-2.4	-2.9	-7.5
Medicare Offset for Employed Beneficiaries	0.0	-1.0	-2.0	-6.0	-8.0	-8.0	-25.0
Total Spending	3.5	23.5	50.9	79.4	88.8	92.1	338.3
Deficit Reduction	11.0	3.2	-6.9	-4.8	18.2	37.7	58.5
Total	14.5	26.7	44.0	74.7	107.0	129.8	396.8

Notes:

These estimates were calculated using the economic assumptions in the 1995 budget. Estimates released in November 1993 were based on the economic assumptions in the 1993 Mid-session Review.

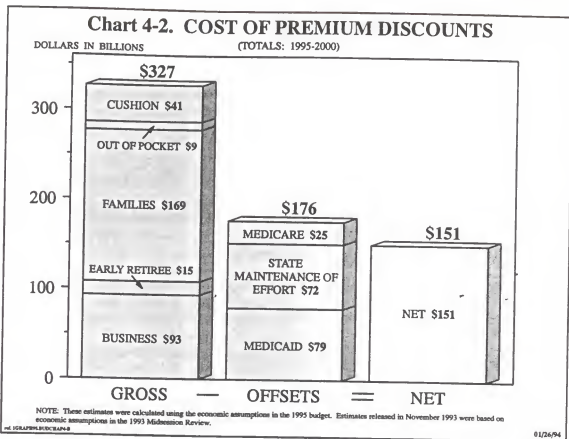
The numbers in this table for the years 1994-1999 are drawn from the budget database, except that they include the Vulnerable Population Adjustment and a Medicare adjustment based on more recent data than were available at the time the budget database was completed.

Federal-State long term care benefit for disabled persons of all ages and income levels. This new benefit includes three major components: a new home and community-based service program for the disabled; liberalized spend-down rules for the Medicaid-eligible institutionalized; and tax incentives for the purchase of long term-care insurance.

100 percent tax deduction for self-employed health insurance (\$9 billion over 1995-2000)—The Act "levels the playing field" by allowing full deduction of self-employed

health insurance premiums, similar to the tax treatment of premiums paid by most businesses today.

Transitional support for public health activities (\$1.6 billion over 1995-2000)—To ensure that the uninsured have adequate access to quality health care during the transition, the Health Security Act authorizes transitional support for selected services. Such support includes funding for community and migrant health centers, an expanded National Health Service Corps, qualified community



Capped Entitlements.—The Federal payments to alliances for the discounts in the Health Security Act for businesses and low-income families are not open-ended. Instead, these payments are capped at specific levels. For any year in which Federal payments to alliances are less than the capped amount specified in the Act, the surplus will be accumulated and made available in future years.

We believe the capped amounts in the Act were estimated conservatively and will not likely be breached. If the President anticipates that the amount of the cap will not be sufficient, he will submit to Congress specific legislative recommendations to eliminate the shortfall. Congress will consider the President's recommendations under an expedited up-down procedure similar to that in the Defense Base Closure and Realignment Act of 1990. The Act enforces accountability by requiring the President and Congress to take specific actions before they can to spend more on discounts.

health plans, and school-based clinics. To ensure that providers who now serve underserved populations (e.g., in community health centers) are brought into the new system, the Act allows HHS to designate these providers temporarily as "essential community providers" with which plans would be required to contract to target underserved populations.

Investments in biomedical and health services research (\$5.1 billion over 1995-2000)—To ensure that American medical

technology and innovation continue to advance under reform, the Act authorizes additional support for biomedical research. To evaluate health reform as it is implemented and to find ways to improve it, the Act also authorizes funds for health services research.

Development of Cost Estimates

The underlying cost estimates of the Health Security Act were carefully developed by experts both inside and outside government

using methods that typically reflected a conservative fiscal outlook.

Experts From Inside and Outside Government.—In estimating the effects on existing government programs, the Office of Management and Budget worked closely with the Department of Health and Human Services and the Council of Economic Advisers. The Department of Treasury estimated the revenue effects and tax-related Medicare provisions. The Administration also sought the expertise of government agencies, think tanks, and consulting firms in developing the premium discount estimates, the most complex component of the Act's costs. A team of private actuaries and health economists also examined and validated the estimation methods and data sources.

Conservative Fiscal Outlook.—The estimates reflect a fiscally conservative approach in assessing the new system. For example, the premium cost estimates are based on the higher of two separate estimates. The phase-in assumptions reflect a realistic view about the speed at which States will enter the new system. Such adjustments and assumptions—including the \$41 billion premium discount "cushion" described above—are typical of the prudent approaches taken in developing the Act's cost estimates.

Treatment of Health Reform in the Budget.—The 1995 budget reflects savings to and expenditures by the Federal Government under the Health Security Act. Specifically, the

Budget includes Medicare and Medicaid savings, and spending on new Medicare benefits and public health activities; premium discounts for small, low-wage firms and low-income families; and revenues from tobacco taxes and corporate assessments. The net total of all the savings and new spending is a \$11 billion reduction in the deficit in 1995 and a \$58 billion reduction over 1995–2000. (See Table 4–3)

When the Health Security Act is enacted, the budget will include information on estimated total premium contributions by employers and consumers. Information on premium payments will be reported much the same way the budget reports financial information on government-sponsored enterprises (GSEs). Alliances, like GSEs, are subject to Federal oversight but otherwise operate *independently* of the Federal Government. Thus, while the National Health Board will approve initial State plans for organizing the alliances and will set alliance premium targets, the Board will not oversee individual alliance budgets, negotiations, or operations. Since the alliances are not Federal entities, premiums paid to the alliances are not Government receipts, and expenditures by the alliances are not Federal expenditures. Therefore, the financial transactions of the alliances are not used to calculate the budget of the Federal Government.

• Table 4–4. HEALTH INVESTMENTS IN THE 1995 BUDGET

(Budget authority; dollar amounts in millions)

	1993 actual	1994 enacted	1995 proposed	Dollar change: 1994 to 1995	Percent change: 1994 to 1995
National Institutes of Health	10,326	10,956	11,473	+517	+5%
Ryan White Act HIV/AIDS Treatment	348	579	672	+92	+16%
Immunizations*	341	528	693	+165	+31%
Drug Treatment for Heavy Users	717	813	1,018	+205	+25%
High Performance Computing	47	58	82	+24	+41%
WIC	2,860	3,210	3,564	+354	+11%
Veterans Medical Care**	14,646	15,622	16,122	+500	+3%

* Includes mandatory vaccine purchase and Medicaid offset

** Excludes \$1 billion in 1995 funding from the Veterans Health Care Investment Fund.

Investments in the 1995 Budget

The 1995 budget contains a number of investments that are building blocks to comprehensive health reform.

National Institutes of Health.—The 1995 budget contains \$11.5 billion for NIH, an increase of \$517 million (4.7 percent) over 1994. NIH supports a number of high priority research areas—including HIV/AIDS, women's health, and high performance computing—that may provide new therapeutic strategies for diseases that are now difficult to treat.

Ryan White Act HIV/AIDS Treatment.—The Health Security Act will provide all Americans—including the sickest and most vulnerable—with community-rated, comprehensive coverage that can never be taken away. Those who are infected with the human immunodeficiency virus (HIV) will, for the first time, have guaranteed coverage for treatment.

In the meantime, the 1995 budget includes \$672 million for programs authorized under the Ryan White Act, an increase of \$92 million (16 percent) over 1994. These funds help people with HIV/AIDS receive HIV testing and counseling services, as well as early treatment. This funding level will be sufficient to provide assistance to an estimated 3 to 7 cities that may become eligible for Title I relief grants in 1995.

Drug Abuse Treatment for Hard-Core Users.—The Health Security Act provides all Americans with coverage for substance abuse treatment services. Substance abuse benefits will be fully phased in after January 1, 2001.

Because heavy drug users are taking an enormous toll on society through violent crime, health costs, and lost productivity, the 1995 budget includes a \$355 million initiative to expand treatment services for heavy users.

Childhood Immunizations.—The Act's comprehensive benefits package covers all rec-

ommended childhood immunizations. In the meantime, to ensure that low-income and uninsured children are immunized prior to the implementation of health reform, the 1995 budget reflects a recently enacted \$424 million program that will purchase vaccine for eligible children and provide it to them free of charge. The vaccine purchase program is designed to sunset upon enactment of comprehensive health reform.

The 1995 budget also includes an additional \$46 million to keep clinics open longer and at more convenient hours, hire more health professionals, and support outreach and education campaigns.

WIC.—The 1995 budget requests almost \$3.6 billion for the Special Supplemental Food Program for Women, Infants, and Children (WIC), a \$354 million increase (11 percent) over 1994. WIC has been shown to play a key role in health promotion by providing nutritional supplements to pregnant women and young children. Fully funding WIC is a priority of the President and will be achieved by the end of 1996 under the 1995 budget and health care reform. (See Chapter 3B for more detail on programs that serve young children.)

Veterans Medical Care.—The 1995 budget includes \$16.1 billion for Veterans Medical Care, an increase of \$500 million over 1994. With these funds, the Department of Veterans Affairs (VA) will maintain its 1994 level of effort and open new medical facilities, including one new hospital and five new nursing homes.

In addition to the amount requested for Medical Care, \$1 billion in 1995 will be provided to VA by the Veterans Health Care Investment Fund established by the Health Security Act. This Investment Fund will provide \$3.3 billion over three years to allow the VA medical care system to make an effective transition to the reformed health care system.

Next Steps: One of the Most Important Debates of the Century

Reform Must Achieve Health Security

On this journey, as on all others of true consequence, there will be rough spots in the road and honest disagreements about how we should proceed. After all, this is a complicated issue. But every journey is guided by fixed stars. And if we can agree on some basic values and principles, we will reach this destination, and we will reach it together.

President Bill Clinton
September 1993

When President Clinton traveled across America, he heard one concern over and over again: Americans want health coverage that cannot be taken away. The plan the Administration presented to Congress responds to Americans' most basic concern about health care, and it reflects the principles to which the President is committed: security, simplicity, savings, choice, quality, and responsibility.

To survive the critical appraisal of the American people, a successful health care reform plan will have to address each of these principles. The Administration has offered one way; others in Congress, to be sure, have different formulations with different priorities. We are flexible on the particulars, but steadfast on the one "fixed star" that we *must* achieve: the security of health

insurance for all Americans that can never be taken away.

Security means that those who do not now have health care coverage will have it, and those who do have it will not have it taken away.

A National Debate

The President has launched a national debate that will allow everyone to learn about the choices necessary to design an American solution. Through continued leadership in the executive and legislative branches, this debate will produce a national consensus on reforming our health care system—and a bill the President can sign this year to make an historic improvement in the health security of all Americans.

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